| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | |
|--|---------------------|---|-------------|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | | 155001 | B. WING | | 07/16/2013 |
| NAME OF F | PROVIDER OR SUPPLIE | ER | | ADDRESS, CITY, STATE, ZIP CODE | |
| | | | | OOVER RD | |
| HOOVEF | RWOOD | | INDIAN | APOLIS, IN 46260 | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG F000000 | REGULATORY O | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| | | | | | |
| | This visit was | for a Recertification and | F000000 | | |
| | State Licensu | | 100000 | | |
| | | .5 64.764. | | | |
| | Survev dates: | July 9, 10, 11, 12, 15, | | | |
| | and 16, 2013 | , , , , , , , , , , , , , , , , , , , | | | |
| | ,, == ., | | | | |
| | Facility number | er: 000001 | | | |
| | Provider numb | | | | |
| | AIM number: | 100275310 | | | |
| | | | | | |
| | Survey team: | | | | |
| | Janet Stanton | , R.NTeam | | | |
| | Coordinator | • | | | |
| | Michelle Hoste | eter, R.N. | | | |
| | Gloria Bond, F | | | | |
| | | | | | |
| | Census bed ty | ype: | | | |
| | SNF/NF161 | | | | |
| | Total161 | | | | |
| | | | | | |
| | Census payor | type: | | | |
| | Medicare9 | | | | |
| | Medicaid108 | 3 | | | |
| | Other44 | | | | |
| | Total161 | | | | |
| | | | | | |
| | | ncies reflect State | | | |
| | . • | in accordance with 410 | | | |
| | IAC 16.2. | | | | |
| | | | | | |
| | | w was completed by | | | |
| | Tammy Alley | RN on July 23, 2013. | | | |
| | | | | | |
| LABORATOR | Y DIRECTOR'S OR PRO | OVIDER/SUPPLIER REPRESENTATIVE'S S | IGNATURE | I TITLE | (X6) DATE |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2013 FORM APPROVED OMB NO. 0938-0391

| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155001 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | COM | e survey pleted 6/2013 | | |
|--------------------------|----------------------------------|--|--|--|------------------------------------|------------------------------|--|--|
| NAME OF P | ROVIDER OR SUPPLIEF | R | | ADDRESS, CITY, STATE, ZIP C | ODE | | | |
| HOOVER | RWOOD | | 7001 HOOVER RD INDIANAPOLIS, IN 46260 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY) | RECTION HOULD BE APPROPRIATE | (X5) COMPLETION DATE | | |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E4J11

Facility ID: 000001

If continuation sheet

Page 2 of 36

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MU | JLTIPLE CO | ONSTRUCTION | (X3) DATE : | SURVEY |
|--|----------------------|------------------------------|-----------------------|------------|--|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING COMPLETED | | | ETED | |
| | | 155001 | | | | 07/16/ | 2013 l |
| | | | B. WINC | | ADDRESS STATE OF SORE | | |
| NAME OF P | ROVIDER OR SUPPLIER | L | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | OOVER RD | | |
| HOOVER | RWOOD | | | INDIAN | APOLIS, IN 46260 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | • | ID | BROWING BY AN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL |] | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | DATE |
| F000247 | 483.15(e)(2) | | | | | | |
| SS=A | RIGHT TO NOTIC | CE BEFORE | | | | | |
| 00 /1 | ROOM/ROOMM | | | | | | |
| | | e right to receive notice | | | | | |
| | | nt's room or roommate in | | | | | |
| | the facility is char | nged. | | | | | |
| | - | view and record | F000 | 0247 | No Plan of Correction required | l. | 08/14/2013 |
| | | ility failed to ensure a | | * | 1 | | |
| | - | otified regarding a | | | | | |
| | | <u> </u> | | | | | |
| | | nge for 1 of 8 residents | | | | | |
| | _ | garding roommate | | | | | |
| | change notifica | ition. (Resident #37) | | | | | |
| | | | | | | | |
| | Findings includ | le· | | | | | |
| | | | | | | | |
| | During on inter | viou on 7/10 /2012 of | | | | | |
| | _ | view on 7/10 /2013 at | | | | | |
| | - | ident #37 indicated | | | | | |
| | she had not be | en notified regarding a | | | | | |
| | roommate char | nge. | | | | | |
| | | | | | | | |
| | The record for | Resident #37 was | | | | | |
| | | 16/2013 at 2 P.M. | | | | | |
| | | | | | | | |
| | | indicating the resident | | | | | |
| | | ed of roommate | | | | | |
| | change was no | ot found. | | | | | |
| | | | | | | | |
| | During an inter | view on 7/16/2013 at | | | | | |
| | _ | ial Service Director #7 | | | | | |
| | · · | re Plan regarding a | | | | | |
| | | | | | | | |
| | • | nmates was completed | | | | | |
| | = | coming to the room, | | | | | |
| | and not the per | rson who was already | | | | | |
| | in the room. | | | | | | |
| | | | | | | | |
| | 3.1-3(v)(2) | | | | | | |
| | 0.1 0(v)(Z) | | | | | | |
| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E4J11

Facility ID: 000001

If continuation sheet Page 3 of 36

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CO | | (X3) DATE SURVEY |
|--|----------------------|--|------------------|---|-------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 155001 | A. BUILDING | 00 | COMPLETED 07/16/2013 |
| | | 100001 | B. WING | ADDRESS CITY STATE ZIR CODE | 31710/2010 |
| NAME OF P | PROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP CODE OOVER RD | |
| HOOVER | | | INDIAN | APOLIS, IN 46260 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX TAG | | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION DATE |
| TAG | REGULATORT OR | LSC IDENTIFTING INFORMATION) | IAG | | DATE |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E4J11

Facility ID: 000001

If continuation sheet Page 4 of 36

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
|--|---------------------|---|------------------|--|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | | 155001 | B. WING | | 07/16/2013 |
| | | | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF F | PROVIDER OR SUPPLIE | R | | OOVER RD | |
| HOOVEF | N/OOD | | | IAPOLIS, IN 46260 | |
| TIOOVER | (VVOOD | | INDIAN | MAFOLIS, IN 40200 | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | REGULATORY OI | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| F000279 | 483.20(d), 483.2 | . , . , | | | |
| SS=D | | PREHENSIVE CARE | | | |
| | PLANS | | | | |
| | | se the results of the | | | |
| | | evelop, review and revise | | | |
| | line resident's co | mprehensive plan of care. | | | |
| | The facility must | develop a comprehensive | | | |
| | | ch resident that includes | | | |
| | | ectives and timetables to | | | |
| | | s medical, nursing, and | | | |
| | mental and psyc | hosocial needs that are | | | |
| | identified in the | comprehensive assessment. | | | |
| | | | | | |
| | | ust describe the services | | | |
| | | nished to attain or maintain | | | |
| | I - | ghest practicable physical, | | | |
| | | chosocial well-being as 483.25; and any services | | | |
| | | wise be required under | | | |
| | | not provided due to the | | | |
| | | se of rights under §483.10, | | | |
| | | nt to refuse treatment under | | | |
| | §483.10(b)(4). | | | | |
| | Based on obse | ervation, interview and | F000279 | | 08/14/2013 |
| | record review. | the facility failed to | | F279 | |
| | | cific Care Plan | | | |
| | | eatment and services to | | | |
| | | | | | |
| | | ealing of an open | | | |
| | l - | of the mid-back spinal | | 1. Resident #217 was not | |
| | · · | ident who was admitted | | affected by this deficient pract | ice |
| | | area which healed | | The Resident's pressure area | |
| | before dischar | ge, in a sample of 4 | | the mid-back spine was | - |
| | residents revie | ewed for pressure | | completely healed upon | |
| | ulcers. (Resid | lent #217) | | discharge to home. Resident | had |
| | ` | • | | no other skin breakdown durir | • |
| | Findings inclu | de· | | her admission. The wheelcha | |
| | | ωο. | | and cushion utilized by reside | nt |
| | On 7/40/40 -4 | O.45 A.M. hus ONA- | | during admission belonged to | |
| | On 7/10/13 at | 9:45 A.M., two CNAs | | resident and was used in | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E4J11

Facility ID: 000001

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) | | | (X3) DATE S | SURVEY | |
|--|---------------------|---------------------------------|---------|--------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DIII | LDING | 00 | COMPLI | ETED |
| | | 155001 | B. WIN | | | 07/16/ | 2013 |
| | | 1 | B. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | OOVER RD | | |
| HOOVER | SMOOD | | | | APOLIS, IN 46260 | | |
| | | | | | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | | | DATE |
| | | I to transfer Resident | | | accordance with resident's | | |
| | #217 into bed | following the breakfast | | | preference. It is believed that | hor | |
| | meal. The res | ident had been sitting | | | resident's complaint of pain in back was due to other clinical | ilei | |
| | in a wheelchai | r in her room, and told | | | conditions not relating to her | | |
| | the staff her ba | ack was "really hurting" | | | healed pressure area. | | |
| | | eeded to lay down. | | | · | | |
| | | bed had a Low Air | | | | | |
| | | relieving mattress. | | | | | |
| | | r was observed to have | | | 2. As a quality improvement | | |
| | | | | | measure, the medical records skin care documentation of all | | |
| | • | e-reducing pad on the | | | current and future residents w | | |
| | seat, but no pa | adding on the back. | | | alteration in skin integrity will b | | |
| | | | | | reviewed by Nursing | | |
| | | review of the clinical | | | Administration and Wound | | |
| | record was do | ne on 7/11/13 at 12:43 | | | Nurse. (Record reviews of | | |
| | P.M. An "Adm | ission Nursing | | | current residents will be | | |
| | Assessment" f | orm, dated 6/26/13 at | | | completed by 8/14/13. Record | | |
| | 2:30 P.M., indi | cated the resident was | | | review of future residents will I | | |
| | admitted that of | lay with a "4 by 4 cm. | | | ongoing). The clinical review of these records will assure that | OI | |
| | | lark brown area, not | | | care plans are current and | | |
| | | yx." The form also | | | specific for the appropriate | | |
| | l . | esident had a Stage 2 | | | interventions of pressure area | s. | |
| | | of the mid-back at the | | | Any deficient practices identific | | |
| | l • | | | | as a result of these record aud | | |
| | _ · | asurements of 0.5 by | | | will be followed up immediatel | | |
| | 0.5 cm. | | | | through disciplinary action, po | , | |
| | | | | | development, and / or mandat inservice education. | eu | |
| | | n Healing Record" form, | | | inscriuce education. | | |
| | dated 7/4/13, i | ndicated the resident | | | | | |
| | had been adm | itted on 6/26/13 with a | | | | | |
| | Stage 2 pressu | ure ulcer of the | | | 3. Upon admission, the | | |
| | mid-back spine | e area, and was | | | admitting nurse and Nursing | | |
| | "healed/scabb | • | | | Supervisor, will be responsible | | |
| | assessment da | | | | assuring that skin pressure are | | |
| | | | | | are accurately addressed in the resident's care plan. This | e | |
| | On 7/12/13 at | 9:50 A.M., Resident | | | practice and standard will also | , | |
| | | · | | | assure that any pressure area | | |
| | #217 was obse | erved to be laying in | | | l accure that any pressure area | ~ | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|----------------------|--------------------------------|--------|--------|--|---------------------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RIII | LDING | 00 | COMPLETED |
| | | 155001 | B. WIN | | | 07/16/2013 |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | PROVIDER OR SUPPLIEI | R | | | OOVER RD | |
| HOOVER | RWOOD | | | | APOLIS, IN 46260 | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | `` | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | |
| TAG | | R LSC IDENTIFYING INFORMATION) | | TAG | · · | DATE |
| | 1 | A transport-type | | | identified throughout a resident admission will also be accurate | • • • • • • • • • • • • • • • • • • • |
| | | s observed parked in | | | addressed in the resident's ca | - |
| | | There was an "Ergo | | | plan. The Unit Manager, Nurs | |
| | Seat" pad on s | • | | | Administration, Nursing | |
| | · · | nich was 1 inch thick, | | | Supervisors, and / or MDS | |
| | | urface on the under | | | Assessment Nurses will be | |
| | | as no padding on the | | | responsible for reviewing admission care plans within 4 | 8 |
| | upper back pa | rt of the wheelchair. | | | hours of admission to assure t | |
| | | | | | all pressure areas are specific | |
| | The resident w | as discharged to her | | | addressed in the care plan. | |
| | previous living | arrangements on | | | | |
| | 7/12/13, at 10: | 45 A.M. | | | | |
| | | | | | An inservice for licensed nursi | na |
| | A further clinic | al record review was | | | personnel will be conducted by | • |
| | done on 7/15/1 | 13 at 10:50 A.M. The | | | 8/14/13 to review this deficient | |
| | resident was a | dmitted on 6/26/13 with | | | practice and to discuss the pla | • • • • • • • • • • • • • • • • • • • |
| | diagnoses whi | ch included, but were | | | of correction, care plan audits, | |
| | not limited to, | end-stage renal | | | ongoing monitoring, etc. | |
| | disease on her | modialysis, | | | | |
| | scleroderma (a | a progressive skin | | | | |
| | · · | othyroidism, and | | | Any deficient practice | |
| | anemia. | , | | | identified as a result of care pl | an |
| | | | | | audits by the Unit Manager, Nursing Administration, Nursir | ng |
| | Physician orde | ers for treatment and an | | | Supervisors, and / or MDS | '8 |
| | ' | n with interventions for | | | Assessment Nurses will be | |
| | | e resident's mid-back | | | addressed immediately throug | h |
| | spine area wei | | | | disciplinary action, policy | . [|
| | | | | | development, and / or mandat inservice education. Any trend | |
| | In an interview | on 7/16/13 at 10:00 | | | of deficient practice will be | 13 |
| | | indicated she had | | | reported by Nursing | |
| | · · | ans addressing skin | | | Administration in a written repo | ort |
| | issues. | and addressing skin | | | to the Quality Improvement | |
| | 100000. | | | | Committee on a monthly basis | i. |
| | Δn initial Care | Plan entry, dated | | | Such monitoring efforts will continue ongoing as a continu | ous |
| | | essed a problem of | | | quality improvement measure. | • • • • • • • • • • • • • • • • • • • |
| | j orzorio, addie | sseu a problem or | | | ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING (COMPLETED) | | | | ETED | |
|--|--|--|--------|---------------------|--|--------|----------------------------|
| | | 155001 | B. WIN | | | 07/16/ | 2013 |
| NAME OF I | PROVIDER OR SUPPLIE | R | | 7001 H | ADDRESS, CITY, STATE, ZIP CODE OOVER RD APOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | evidenced by: listed in the fo and "Risk for | skin integrity as ," with no information llowing blank space; skin breakdown related mobility, debility." | | | 5. Date of Completion: 8/14/13 | | |
| | area every sh or lack of prog and dry; Provi by the physici and dry; Press Low Air Loss | ons listed were: "Assess ift; document progress gress; Keep skin clean de treatment as ordered an; Keep linens clean sure relieving device(s): mattress 6/27/13; 1-100% of food and fluid is." | | | | | |
| | listed for treat | o specific interventions ment or services related the resident's mid-back | | | | | |
| | 7/5/13, had ar a problem of " alteration in sl | Care Plan, dated n entry which addressed Resident is at risk for kin integrityOn by 0.5 open area spine | | | | | |
| | limited to, the Administer tre Provide press bed and chair prominences | following: "4. atments as ordered; 5. ure relieving devices to ; 6. Observe bony for redness;8. 7/9/13- on provided; 9. 6/27/13- | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E4J11

Facility ID: 000001

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2013 FORM APPROVED OMB NO. 0938-0391

| | NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155001 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | COM | E SURVEY PLETED 6/2013 | |
|--------------------------|--|---|--|---------|----------------------------|--|
| | PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE 7001 HOOVER RD INDIANAPOLIS, IN 46260 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| | -Low Air Loss mattress." In an interview on 7/16/13 at 10:00 A.M., R.N. #7 indicated there had never been a treatment order for mid-spine area. 3.1-35(b)(1) | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E4J11

Facility ID: 000001

If continuation sheet

Page 9 of 36

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155001 | | | A. BUIL | LDING | 00 | (X3) DATE (COMPL 07/16 / | ETED |
|--|---|--|---------|---------------------|---|--|----------------------------|
| | | 133001 | B. WIN | | | 077107 | 2013 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 7001 H | ADDRESS, CITY, STATE, ZIP CODE OOVER RD | | |
| HOOVEF | RWOOD | | | INDIAN | APOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | (X5) COMPLETION DATE |
| F000314 SS=D | PRESSURE SOF Based on the cona resident, the fact resident who enterpressure sores do sores unless the condition demons unavoidable; and sores receives ne services to promoting to the pressure sore of developing. Based on observed review, implement treat promote the het pressure sore of area, for 1 residuith the open and discharge, in a reviewed for president #217. Findings included On 7/10/13 at 9 were observed #217 into bed for meal. The resident staff her based her, and she not the resident's Loss pressure- | nprehensive assessment of cility must ensure that a sers the facility without the period of the pressure individual's clinical strates that they were a resident having pressure excessary treatment and one healing, prevent went new sores from arvation, interview, and the facility failed to the them and services to realing of an open of the mid-back spinal dent who was admitted area that healed before sample of 4 residents ressure ulcers. | F00 | 0314 | 1. Resident #217 was not affected by this deficient practi. The Resident's pressure area the mid-back spine was completely healed upon discharge to home. Resident no other skin breakdown durin her admission. The wheelcha and cushion utilized by resider during admission belonged to resident and was used in accordance with resident's preference. It is believed that resident's complaint of pain in back was due to other clinical conditions not relating to her healed pressure area. The "Wound / Skin Healing Record" dated 6/26/13 which indicated the Stage 2 pressure | of had g ir nt her | 08/14/2013 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E4J11

Facility ID: 000001

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY |
|--|------------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING O | COMPLETED |
| 155001 B. WING | 07/16/2013 |
| STREET ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF PROVIDER OR SUPPLIER 7001 HOOVER RD | |
| HOOVERWOOD INDIANAPOLIS, IN 46260 | |
| TIOOVERWOOD INDIANALOEIS, IN 40200 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTI | |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO | PRIATE |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) | DATE |
| a thin pressure-reducing pad on the wound of the coccyx was a | |
| seat, but no padding on the back. | |
| admitting Registered Nurso | |
| In an interview on 7/10/13 at 9:50 the word "coccyx" instead "mid-spine." The Unit Man | |
| A.M., Resident #217 indicated she informed the surveyor of the | |
| goes to a hemodialysis facility "early documentation error during | |
| good to a normodiaryole facility barry | |
| on a low air loss mattress to | |
| Thursdays, and Saturdays, and "gets 24 hours of admission. The | |
| Mondays off." She indicated she was pressure area completely in | |
| in the facility for a short-stay only, and without topical treatment, t | |
| would be going back to her former 7/4/13, and the resident was | |
| living arrangements "soon." discharged to home on 7/1 | |
| without any additional skin | issues. |
| In an interview on 7/10/13 at 2:20 | |
| P.M., R.N. #7 indicated Resident | |
| #217 did not have any pressure 2. As a Quality Improver | nent |
| ulcers. Measure, the skin treatmen | |
| orders for pressure ulcers | of all |
| current and future resident | |
| An initial brief review of the clinical be reviewed by the Nursing | |
| record was done on 7/11/13 at 12:43 Administration, Unit Management of the state o | |
| P.M. An "Admission Nursing Nursing Supervisor, and / 6 Wound Nurse. (Record re | |
| Assessment" form, dated 6/26/13 at of current residents will be | views |
| 2:30 P.M., indicated the resident was audited by 8/14/13. Recor | d I |
| admitted that day with a "4 by 4 cm. review of future residents v | |
| [centimeters] dark brown area, not ongoing and audited within | |
| open, on coccyx." The form also | oractice |
| indicated the recident had a Stage 2 | |
| any pressure areas identifi | |
| pressure area of the mid-back at the throughout a resident's add | |
| spine, with measurements of 0.5 by will also be accurately add | essed |
| 0.5 cm. with skin treatments / interventions. The clinical | review |
| of these records will assure | |
| The 2008 AMDA (American Medical the treatment orders are co | |
| Directors Association) "Pressure and specific for the approp | |
| Ulcers in the Long-Term Care interventions of pressure a | |
| Setting" Clinical Practice Guideline Any deficient practices ide | ntified |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DA | | (X3) DATE SU | JRVEY | | |
|--|---------------------|------------------------------------|-----------|--------------------------|---|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DIJII D | A. BUILDING 00 COMPLETED | | | ΓED |
| | | 155001 | B. WING | ING | | 07/16/20 | 013 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | OOVER RD | | |
| HOOVER | RWOOD | | | INDIANAPOLIS, IN 46260 | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | NCY MUST BE PRECEDED BY FULL | | EFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE (| COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | | ΓAG | DEFICIENCY) | | DATE |
| | | bes a Stage 2 pressure | | | as a result of these record aud will be followed up immediately | | |
| | • | rtial thickness loss of | | | through disciplinary action, po | · | |
| | | ting as a shallow open | | | development, and / or mandat | | |
| | | d pink ulcer bed, | | | inservice education. | | |
| | without slough | 1." | | | | | |
| | | | | | | | |
| | | n Healing Record" form, | | | 3. Upon admission, the | | |
| | dated 6/26/13 | , indicated the resident | | | admitting nurse and Nursing | | |
| | had a Stage 2 | pressure wound of the | | | Supervisor will be responsible | for | |
| | coccyx, with m | neasurements of 0.5 by | | | assuring that treatment orders | | |
| | 0.5 cm. There | was no assessment | | | pressure areas are accurate a | nd | |
| | for the area or | n the resident's | | | in place, per physician order. | | |
| | mid-back. | | | | This practice and standard will | | |
| | | | | | also assure that any pressure areas identified throughout a | | |
| | A second "Wo | und/Skin Healing | | | resident's admission will be | | |
| | | dated 7/4/13, indicated | | | accurately addressed with | | |
| | | ad been admitted on | | | physician ordered treatments. | | |
| | | Stage 2 pressure ulcer | | | The Unit Manager, Nursing | | |
| | | k spine area, and was | | | Administration, Nursing | | |
| | "healed/scabb | - | | | Supervisors, and / or MDS Assessment Nurses will be | | |
| | assessment d | | | | responsible for auditing treatm | ent | |
| | assessment u | ate 01 7/4/13. | | | orders within 48 hours of | | |
| | In an intension | on 7/16/12 of 10:59 | | | admission to assure that all | | |
| | | on 7/16/13 at 10:58 | | | pressure areas are appropriate | • | |
| | <u> </u> | indicated she had | | | being addressed with physicia ordered skin treatments, as | n | |
| | | se who had completed | | | necessary. | | |
| | | d assessment form. | | | | | |
| | | oorted that the area of | | | | | |
| | | documented in error, | | | | | |
| | | ve been identified as | | | An inservice for licensed nursi | - | |
| | the mid-back | spine area. | | | personnel will be conducted by | · . | |
| | | | | | 8/14/13 to review this deficient practice and to discuss the pla | | |
| | On 7/12/13 at | 9:50 A.M., Resident | | | of correction, care plan audits, | | |
| | #217 was obs | erved to be laying in | | | ongoing monitoring, etc. | | |
| | bed, asleep. / | A transport-type | | | · · · · · · · · · · · · · · · · · · · | | |
| | • | s observed parked in | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DA | | | (X3) DATE SU | JRVEY | | | |
|---|--------------------------------------|------------------------------|--------------|--------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DITT | LDDIG | 00 | COMPLE | TED |
| | | 155001 | | LDING | | 07/16/2 | 013 |
| | | | B. WIN | | ADDRESS CITY STATE ZID CODE | | |
| NAME OF P | PROVIDER OR SUPPLIEF | 2 | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| HOOVE | NACOD. | | | | OOVER RD | | |
| HOOVER | RWOOD | | | INDIAN | APOLIS, IN 46260 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | the bathroom. | There was an "Ergo | | | |] | |
| | Seat" pad on s | _ | | | Any deficient practice | | |
| | • | nich was 1 inch thick, | | | identified as a result of skin | | |
| | | urface on the under | | | treatment audits by the Unit | | |
| | | | | | Manager, Nursing Administrat | ion, | |
| | | as no padding on the | | | Nursing Supervisors, and / or MDS Assessment Nurses will | ho | |
| | upper back pai | rt of the wheelchair. | | | addressed immediately throug | | |
| | | | | | disciplinary action, policy | "' | |
| | The resident w | as discharged to her | | | development, and / or mandat | ed | |
| | previous living | arrangements on | | | inservice education. Any trend | | |
| | 7/12/13, at 10: | 45 A.M. | | | of deficient practice will be | | |
| | · | | | | reported by Nursing | | |
| | A further clinical record review was | | | | Administration in a written rep | ort | |
| | | 13 at 10:50 A.M. The | | | to the Quality Improvement | | |
| | | | | | Committee on a monthly basis | S. | |
| | | dmitted on 6/26/13 with | | | Such monitoring efforts will | | |
| | _ | ch included, but were | | | continue ongoing as a continu | | |
| | | end-stage renal | | | quality improvement measure. | • | |
| | disease on her | modialysis, | | | | | |
| | scleroderma (a | a progressive skin | | | | | |
| | disease), hypo | thyroidism, and | | | 5. Date of Completion: | | |
| | anemia. | , | | | 8/14/13 | | |
| | anoma. | | | | | | |
| | The CAA (Cor | Aroa Assasament) | | | | | |
| | , | e Area Assessment) | | | | | |
| | , | e MDS (Minimum Data | | | | | |
| | , | ent, dated 7/3/13, | | | | | |
| | indicated the fo | ollowing: | | | | | |
| | | | | | | | |
| | "Nutritional Sta | atus85 year old | | | | | |
| | admitted with [| DiagnosesStage I | | | | | |
| | | on mid spinal back. | | | | | |
| | Will order high | • | | | | | |
| | _ | • | | | | | |
| | | e to weight loss and | | | | | |
| | pressure ulcer. | | | | | | |
| | | | | | | | |
| | Pressure Ulcer | r: Resident at risk for | | | | | |
| | alteration in sk | in integrity due to | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIP | LE CO | NSTRUCTION | (X3) DATE COMPL | | |
|--|---------------------|---|--------------|--------------|---|--------|--------------------|
| AND PLAN | OF CORRECTION | 155001 | A. BUILDING | | 00 | 07/16/ | |
| | | 100001 | B. WING | PPT A | DDDEGG CITY OTATE ZID CODE | 077107 | 2010 |
| NAME OF F | PROVIDER OR SUPPLIE | R | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| HOOVER | RWOOD | | | | APOLIS, IN 46260 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | PREFI TAC | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| TAG | | 's, use of supplemental | IAC | ' | | | DATE |
| | | nnula, and recent | | | | | |
| | , , , | e to scleroderma" | | | | | |
| | 1 | information related to | | | | | |
| | pressure ulcer | | | | | | |
| | P | | | | | | |
| | Physician orde | ers for treatment and an | | | | | |
| | 1 7 | an with interventions for | | | | | |
| | the area on the | e resident's mid-back | | | | | |
| | spine area we | re not found. | | | | | |
| | | | | | | | |
| | | on 7/16/13 at 10:00 | | | | | |
| | · · | indicated she had | | | | | |
| | _ | ans addressing skin | | | | | |
| | issues. | | | | | | |
| | An initial Cara | Dian antry dated | | | | | |
| | | Plan entry, dated essed a problem of | | | | | |
| | | skin integrity as | | | | | |
| | | "," with no information | | | | | |
| | | llowing blank space; | | | | | |
| | | skin breakdown related | | | | | |
| | | mobility, debility." The | | | | | |
| | | isted were: "Assess | | | | | |
| | | ft; document progress | | | | | |
| | 1 | ress; Keep skin clean | | | | | |
| | | de treatment as ordered | | | | | |
| | by the physicia | an; Keep linens clean | | | | | |
| | and dry; Press | sure relieving device(s): | | | | | |
| | | mattress 6/27/13; | | | | | |
| | _ | -100% of food and fluid | | | | | |
| | intake at meal | S." | | | | | |
| | There were no | specific interventions | | | | | |
| | | ment or services related | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E4J11

Facility ID: 000001

If continuation sheet Page 14 of 36

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2013 FORM APPROVED OMB NO. 0938-0391

| | T OF DEFICIENCIES OF CORRECTION | IDENTIFICATION NUMBER: | (X2) M | ULTIPLE CO. | NSTRUCTION | (X3) DATE S COMPL | |
|---------------|--|---|--------|---------------|---|----------------------|--------------------|
| MOLLAN | or connection | 155001 | | LDING | 00 | 07/16/ | |
| | | 100001 | B. WIN | | DDDDGG GWW GW W GO | 377107 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | DOVER RD | | |
| HOOVER | WOOD | | | | APOLIS, IN 46260 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| 1710 | | the resident's mid-back | | 1710 | · | | DATE |
| | | and rediceding time back | | | | | |
| | 7/5/13, address "Resident is at skin integrity | atments as ordered; 5. are relieving devices to 6. Observe bony or redness;8. 7/9/13- n provided; 9. 6/27/13- mattress." on 7/16/13 at 10:00 ndicated the facility Low Air Loss mattress e resident was indicated she had e Therapy Department, eported they had HO (a brand name ing seat device) ter admission. The d she did not know why ould have been in a wheelchair unless it ersonal property. The cated there had never ent order for mid-spine rier cream had been | | | | | |
| | nurse also indicate been a treatme | cated there had never ent order for mid-spine rier cream had been | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E4J11

Facility ID: 000001

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2013 FORM APPROVED OMB NO. 0938-0391

| | | IDENTIFICATION NUMBER: 155001 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | COMPI 07/16 | LETED | | | |
|--------------------------|----------------------|---|---|---|-------------|----------------------------|--|--|--|
| NAME OF F | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 7001 HOOVER RD INDIANAPOLIS, IN 46260 | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | | | |
| | 3.1-40(a)(2) | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E4J11

Facility ID: 000001

If continuation sheet

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| | T OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155001 | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 07/16/2013 |
|---|--|---|---------------------------------------|--|---------------------------------------|
| NAME OF P | ROVIDER OR SUPPLIER | | STREET 7001 H | ADDRESS, CITY, STATE, ZIP CODE HOOVER RD NAPOLIS, IN 46260 | |
| (X4) ID PREFIX TAG F000329 SS=D | (EACH DEFICIEN REGULATORY OR 483.25(I) DRUG REGIMEN UNNECESSARY Each resident's d from unnecessary drug is any drug v dose (including diexcessive duratio monitoring; or wit | DRUGS rug regimen must be free rugs. An unnecessary when used in excessive uplicate therapy); or for n; or without adequate hout adequate indications | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | consequences when should be reduce combinations of the Based on a compresident, the facility residents who has drugs are not give antipsychotic drug treat a specific condocumented in the residents who use receive gradual discontraindicated, in these drugs. Based on recondinterview, the factor reduce the discontraindicate the di | acility failed to attempt ose of an medication for 1 of 10 wed for Unnecessary e. (Resident #52) e: Resident #52 was 15/13 at 11:30 A.M. uded, but were not | F000329 | F329 1. Upon clinical review of Resident #52, and in consulta with physician, consulting pharmacist, nursing staff, and social worker, it is believed that Resident #52 was not affected this deficient practice. Even though the physician is a | at I by |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E4J11

Facility ID: 000001

If continuation sheet

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| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
|-----------|---------------------|--------------------------------|------------------------|--|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | | 155001 | A. BUILDING B. WING | | 07/16/2013 |
| | | 1 | | ADDRESS, CITY, STATE, ZIP CODE | L |
| NAME OF I | PROVIDER OR SUPPLIE | R | | OOVER RD | |
| HOOVER | RWOOD | | | IAPOLIS, IN 46260 | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| | depression, his | story of stroke, and | | currently planning to reduce the | |
| | breast cancer. | The resident was | | Cymbalta, especially while the | 9 |
| | admitted to the | e facility in March, 2011 | | prescribed administration of Seroquel (antipsychotic) is | |
| | from an acute | care hospital with a | | currently being reduced, the | |
| | diagnosis of hi | gh anxiety. | | indication for usage will be | |
| | | · · | | reviewed by the physician and | d |
| | The physician' | s order recapitulation | | pharmacist and possibly chan | |
| | | 2013 indicated the | | from "Anxiety" to "Depression | 1 |
| | 1 | een on Cymbalta (an | | Osteoarthritis." | |
| | | t medication) 60 mg. | | | |
| | - | ally for anxiety since | | | |
| | 3/28/11. | any for anxiety since | | 2. The "indications for usag | je" |
| | 3/20/11. | | | of all residents currently | |
| | A may take le siet | was areas material | | prescribed with anti-depressa | |
| | | progress note, dated | | will be reviewed by nursing st | |
| | · · | ited the resident was | | social services, physician, and pharmacists during monthly | a |
| | | any anxiety, and there | | pharmacy audits. Any | |
| | | viors or problems with | | recommended indications for | |
| | the resident's r | | | usage or gradual dose reduct | ions |
| | psychologist st | topped seeing the | | will be presented to the physic | cian |
| | resident as of | 3/22/12. | | for approval. | |
| | | | | | |
| | | ogress notes indicated | | | |
| | the resident ha | | | 3. This deficient practice wi | ill be |
| | | medication from | | discussed during ongoing | |
| | 9/18/12. The o | dosage was decreased | | monthly pharmacy audits, | |
| | on 11/6/12 due | e to her not having | | monthly Quality Improvement Committee meetings, monthly | |
| | psychosis, or a | any more episodes of | | behavior meetings with the | |
| | anxiety. | | | geriatric psychiatrist, and care | |
| | | | | plan meetings. Residents | |
| | Physician's pro | ogress notes from | | identified for possible gradual | |
| | | h 7/14/13 indicated the | | dose reductions will be present | nted |
| | | o mood or behavior | | to the physician for approval. | |
| | | was no documentation | | | |
| | | ttempt for reduction or | | | |
| | _ | n of the Cymbalta 60 | | An inservice for licensed nurs | ing |
| | | i oi tilo Oyilibalta 00 | 1 | I | - |

| NAME OF PROVIDER OR SUPPLIER HOOVERWOOD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) In an interview on 7/15/13 at 11:00 A.M., LPN #3 and the Social Services Director (SSD) each indicated they were not aware of the resident having any anxiety. The nurse indicated she STREET ADDRESS, CITY, STATE, ZIP CODE 7001 HOOVER RD INDIANAPOLIS, IN 46260 INDIANAPOLIS, IN 46260 ID PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE and social services personnel will be conducted by 8/14/13 to review this deficient practice and to discuss the plan of correction. This deficient practice will also be discussed with Hooverwood's medical directors and consulting pharmacist by 8/14/13. | | IENT OF DEFICIENCIES AN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155001 | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 07/16/2013 |
|---|--------|--|---|--------------------------------------|---|---------------------------------------|
| PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) mg. had been considered. In an interview on 7/15/13 at 11:00 A.M., LPN #3 and the Social Services Director (SSD) each indicated they were not aware of the resident having any anxiety. The nurse indicated she (EACH DEFICIENCY) PREFIX TAG PREFIX TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) and social services personnel will be conducted by 8/14/13 to review this deficient practice and to discuss the plan of correction. This deficient practice will also be discussed with Hooverwood's medical directors and consulting pharmacist by 8/14/13. | | | 1 | STREET 7001 H | HOOVER RD | |
| In an interview on 7/15/13 at 11:00 A.M., LPN #3 and the Social Services Director (SSD) each indicated they were not aware of the resident having any anxiety. The nurse indicated she be conducted by 8/14/13 to review this deficient practice and to discuss the plan of correction. This deficient practice will also be discussed with Hooverwood's medical directors and consulting pharmacist by 8/14/13. | PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | COMPLETION DATE |
| was not aware of any attempts for a reduction in Cymbalta. During the interview, the Social Services Director indicated licensed nurses documented behaviors in the clinical record nursing notes for each resident who displayed a behavior. Any staff could use the forms in the orange tracking log book to document observed behaviors or concerns a resident might have, using 1 form for each resident who displayed a behavior. She would then develop a tracking "calendar" from the tracking book for that specific resident and behavior. There was no documentation in nurses notes or any behavior tracking forms found in record indicating the resident had any anxiety or depression symptoms from 6/29/12 through 7/14/13. 3.1-48(b)(2) | | In an interview A.M., LPN #3 a Director (SSD) were not aware any anxiety. The was not aware reduction in Cy During the intervices Director of the intervices document clinical record resident who do any staff could orange tracking observed behavior. She tracking "calent book for that subsequent in the intervices of the intervices of the intervices of the intervices of the interview of the intervices of the interview of the inter | on 7/15/13 at 11:00 and the Social Services each indicated they e of the resident having the nurse indicated she of any attempts for a ymbalta. Erview, the Social tor indicated licensed ented behaviors in the nursing notes for each isplayed a behavior. I use the forms in the g log book to document aviors or concerns a have, using 1 form for who displayed a would then develop a adar" from the tracking pecific resident and documentation in or any behavior tracking record indicating the ny anxiety or enptoms from 6/29/12 | | be conducted by 8/14/13 to review this deficient practice at to discuss the plan of correction. This deficient practice will also discussed with Hooverwood's medical directors and consulting pharmacist by 8/14/13. 4. Any trends of identified residents in need of gradual directors will be presented by consulting pharmacist on a quarterly basis during the qualimprovement committee meetings. Continued identification of residents lack attempts of gradual dose reduction will be carefully addressed by the Medical Director. | ond on. o be ing |

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Event ID: 2E4J11

Facility ID: 000001

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI | | | SURVEY | |
|--|--|--|--|---------|---|----------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | DING | 00 | COMPL | ETED |
| | | 155001 | B. WIN | | | 07/16/ | 2013 |
| | | | В. (ГП) | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | OOVER RD | | |
| HOOVER | N/OOD | | | | APOLIS, IN 46260 | | |
| TIOOVEI | (VVOOD | | | IINDIAN | Al OLIO, IN 40200 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | ГЕ | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| F000371 SS=F | The facility must - (1) Procure food of considered satisfal local authorities; a (2) Store, prepare under sanitary con Based on observe of the follow correct hairnets and disprevent cross-of for 1 of 1 facility deficient practice. | rom sources approved or actory by Federal, State or and e, distribute and serve food nditions rvation, interview and the facility failed to equipment, and failed et procedures for use of sposable gloves to contamination of food, | F00 | 0371 | F371 1. No residents were found have been affected by these deficient practices due to no reports or complaints of illness identified during this time. | | 08/14/2013 |
| | completed on 7 with the Dieticia Director and the Manager in attempts. The following war A. A fan with don the blades where clean sil | observation tour was 7/9/13 at 10:04 A.M., an/Food Service e Food Service endance. vas observed: lark particulate matter was blowing into area verware was exposed. | | | 2. Due to the correction actimmediately taken as a result of these deficient practices, there were no other residents identification with the potential of being affected by this same deficient practice. The correction actions immediately taken were as follows: | of e ied | |
| | Dietician indica | at that time, the ited this was an area staff dished up food. | | | The fan was thoroughly cleane and removed from the kitchen area. The plate warmer was thoroughly cleaned. {see | ed | |

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Event ID: 2E4J11

Facility ID: 000001

If continuation sheet

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| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE S | SURVEY |
|-----------|-----------------------|--------------------------------|--------|------------|---|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | ETED |
| | | 155001 | B. WIN | | | 07/16/ | 2013 |
| NAME OF A | DROLUBER OR GURRI IEI | | _ | STREET A | ADDRESS, CITY, STATE, ZIP CODE | • | |
| NAME OF I | PROVIDER OR SUPPLIE | К | | 7001 H | OOVER RD | | |
| HOOVER | RWOOD | | | INDIAN | IAPOLIS, IN 46260 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | | TAG | · | | DATE |
| | | | | | attachment #1} | | |
| | • | rmer was observed to | | | | | |
| | have visible dr | ied food spillage on it. | | | | | |
| | | | | | The steam table was discarde | d | |
| | C. The steam | table had a large | | | and replacement is on order. | All | |
| | amount of drie | d food matter on the | | | frozen food items were | | |
| | bottom section | and around the steam | | | immediately removed from the | | |
| | table legs. | | | | freezer and placed in the walk freezer. The freezer was | -111 | |
| | | | | | discarded and replacement is | on | |
| | In an interview | on 7/9/13 at 10:25 | | | order. {see attachment #2, | | |
| | A.M., the Dieti | cian indicated these | | | pg1-4} | | |
| | areas were to | be cleaned weekly. | | | | | |
| | | · | | | | | |
| | On 7/9/13 at 1 | 2:05 P.M., an | | | The non-dietary employee with | nout | |
| | | on-dietary employee | | | a hair net received disciplinary | | |
| | | walking into the | | | action. This employee's | | |
| | | ast the steam table | | | department / co-workers | | |
| | · · | as ready to be served. | | | participated in an inservice | | |
| | | did not have a hair net | | | regarding this deficient practic | e. | |
| | on. | ala not navo a nan not | | | {see attachment #3, pg 1-2} | | |
| | " | | | | | | |
| | On 7/9/13 at 1 | 2·20 P.M. an | | | | | |
| | unidentified die | - | | | The dietary employee received | | |
| | | long braids hanging out | | | disciplinary action regarding the | ne | |
| | | 0 0 | | | use of hair net and gloves. | | |
| | | while going in and out | | | Another dietary employee received disciplinary action | | |
| | | She walked by the | | | regarding the freezer tempera | ture | |
| | · · | om which the prepared | | | logs. {see attachment #4, pg | | |
| | | e served, and back out | | | 1-2} | | |
| | | nt dining area to serve | | | | | |
| | residents their | tood. | | | | | |
| | The same unio | dentified dietary side | | | 3. The Food Service Director | or | |
| | | dentified dietary aide | | | had a meeting with the dietary | | |
| | | to go into the kitchen, | | | employees to review these | | |
| | _ | d hands, touch the | | | deficient practices. Cleaning | | |
| | retrigerator ha | ndle to open the | | | assignments, temperature log | S, | |

| STATEMENT OF ! | TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY | | | EΥ | | | |
|-----------------|---|------------------------------|---------|--------|---|------------|----------|
| AND PLAN OF CO | PRRECTION | IDENTIFICATION NUMBER: | A RIII | LDING | 00 | COMPLETED | |
| | | 155001 | B. WIN | | | 07/16/2013 | |
| | | | D. WII. | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF PROVII | DER OR SUPPLIER | L | | | OOVER RD | | |
| HOOVERWOO | OD | | | | APOLIS, IN 46260 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | • | CY MUST BE PRECEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIATE | | IPLETION |
| | | LSC IDENTIFYING INFORMATION) | | TAG | | <u>_</u> | DATE |
| | - | get a can of soda pop | | | use of hair net, use of gloves, food handling, etc., were all | | |
| | | Without changing the | | | carefully reviewed by the Food | | |
| | gloves or washing her hands, the aide | | | | Service Director. {see | | |
| pro | oceeded to g | o back into dining | | | attachment #5 pg, 1-2} | | |
| roc | om and give | the can of pop to the | | | . 5. | | |
| res | sident. With | out changing the | | | | | |
| glo | ves or wash | ing her hands, the aide | | | A | . | |
| wa | s observed | to hold tongs in one | | | A posting, regarding the requiruse of a hairnet and a supply of | | |
| ha | nd and a sal | ad bowl in the other. | | | hairnets, has been placed at | " | |
| Sh | e used the t | ongs to scoop up some | | | every entrance to the kitchen. | | |
| | | e in the bowl. While | | | {see attachment #6 pg, 1-2} | | |
| | • | ouched the raw salad | | | | | |
| | th her gloved | | | | | | |
| | g.c.g.c.c | | | | These deficient prostices will be | _ | |
| l _{In} | an interview | on 7/16/13 at 11:25 | | | These deficient practices will be closely monitored by the Food | e | |
| | | cian indicated he | | | Service Director, Food Service | | |
| | | oyees to remove their | | | Manager, and the Chefs. In | | |
| | | sh their hands before | | | addition, the Executive Directo | r, | |
| 1 - | | | | | Chief Financial Officer, and / o | | |
| | • . | id. He also indicated if | | | the Infection Prevention Nurse | | |
| | | re around the food prep | | | will be conducing unannounce bi-weekly sanitation rounds for | | |
| | - | there would be | | | three months. Following these | | |
| | | e food, they should | | | bi-weekly rounds, monthly rou | | |
| _ | | on with the hair | | | will be completed on an ongoin | | |
| COI | ntained and | secured. | | | basis. The results of the mont | hly | |
| | | | | | rounds will be reported at the | | |
| | | 11:35 A.M., the | | | monthly Quality Improvement committee meetings. | | |
| | - | ded an undated | | | committee meetings. | | |
| 1 ' | • . | re titled "Dietary Food | | | | | |
| Ha | indling Policy | y." The policy | | | | | |
| ind | licated, "1. | The kitchen and | | | Further observations of deficie | nt | |
| eq | uipment are | clean Hairnets and | | | practices involving sanitation, | | |
| glo | ves are to b | e worn when serving | | | temperature readings, food | | |
| | | erving line or in the | | | handling, use of hairnet and gloves, etc., will be addressed | | |
| | | om when serving | | | immediately with disciplinary | | |
| | - | ure gloves do not | | | action, policy development, an | a | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E4J11

Facility ID: 000001

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION | | ONSTRUCTION | (X3) DATE | SURVEY | | | |
|--|---|-----------------------------------|-------------------|--------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DITT | DDIC | 00 | COMPL | ETED |
| | | 155001 | A. BUII B. WIN | LDING | | 07/16/ | 2013 |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEI | R | | | OOVER RD | | |
| HOOVER | SMOOD | | | | APOLIS, IN 46260 | | |
| | | | _ | | 7 (1 OLIO, IIV 40200 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX | ` | NCY MUST BE PRECEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | - | TAG | | | DATE |
| | | tact with non-food | | | mandated inservice training. | | |
| | · · | ables clothing etc.). | | | | | |
| | | s as necessary and | | | | | |
| | follow department hand-washing policy" | | | | 4. Any observation of defici- | ent | |
| | | | | | practices will be communicate | | |
| | | | | | a written report at the monthly | | |
| | Completed cle | aning logs for April | | | Quality Improvement committee | | |
| | through June, 2013 were provided by the Dietician on 7/10/13 at 1 P.M. A | | | | meetings by the Food Service Director, Executive Director, C | | |
| | | | | | Financial Officer and / or the | | |
| | cleaning log fo | ing log for July was not included | | | Infection Prevention Nurse. | | |
| | in the information provided. The log for June 2013 indicated, "Delime all | | | | Trends of re-occurring deficier | nt | |
| | | | | | practices will lead toward | | |
| | | hot wells" There | | | disciplinary action, policy | | |
| | | n the list addressing the | | | development, and mandated inservice training. | | |
| | cleaning of the | _ | | | inservice training. | | |
| | | plate warmer. | | | | | |
| | 2. The kitcher | observation tour was | | | | | |
| | | 7/9/13 at 10:04 A.M., | | | 5. Date of Completion: | | |
| | | an/Food Service | | | 8/14/13 | | |
| | | ne Food Service | | | | | |
| | Manager in att | | | | | | |
| | i wanayei iii all | Challes. | | | | | |
| | At 10:14 A M | the thermometer inside | | | | | |
| | | | | | | | |
| | 1 | reezer indicated the | | | | | |
| | | as currently 22 degrees | | | | | |
| | | rozen cookies were soft | | | | | |
| | | he other items in the | | | | | |
| | | lightly thawed. No | | | | | |
| | | ardous food was | | | | | |
| | observed. | | | | | | |
| | | | | | | | |
| | In an interview | on 7/9/13 at 10:15 | | | | | |
| | A.M., the Dietic | cian indicated he | | | | | |
| | expected the to | emperature of the | | | | | |
| | bakery freezer | to be 0 (zero) degrees | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2013 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION IDENTIFICATION NUMBER: 155001 | A. BUILDING B. WING | <u>00</u> | COMPLETED 07/16/2013 |
|--------------------------|--|----------------------|--|----------------------|
| NAME OF I | PROVIDER OR SUPPLIER | 7001 HOC | DRESS, CITY, STATE, ZIP CODE OVER RD POLIS, IN 46260 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Fahrenheit. | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETION DATE |
| | The July, 2013 bakery freezer temperature logs were provided by the Dietician on 7/10/13. The freezer temperature for the first 8 days of July were documented as ranging from 20-24 degrees Fahrenheit. The freezer temperature logs for the month of June also indicated temperatures ranging from 20 to 24 degrees Fahrenheit. A dietary policy, dated 1/2012, was provided by the Dietician on 7/10/13 at 1:00 P.M. The policy indicated "Each refrigerator and freezer contains a thermometer accurate to 3 degrees Fahrenheit and is easily read. The refrigeration is checked daily in the AM and PM and recorded on the proper form. If the temperature recorded is not within range, report the discrepancy to the supervisor immediately. If the temperature is not appropriate since the last reading was taken, food, especially perishables may need to be discarded" 3.1-19(bb) 3.1-21(i)(3) | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E4J11

Facility ID: 000001

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|----------------------------------|---|-------------------------------------|
| | | 155001 | B. WING | | 07/16/2013 |
| NAME OF P | ROVIDER OR SUPPLIEF | 8 | 7001 H | ADDRESS, CITY, STATE, ZIP CODE HOOVER RD NAPOLIS, IN 46260 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| F000456 SS=F | mechanical, elected equipment in safe Based on observed. Based on observed equipment in safe Based on observed equipment in safe Based on observed, maintain 1 of 3 temperature rakitchen. This opotential to impresidents receikitchen. Findings including the kitchen observed equipment in attention of the bakery for temperature was a potentially haze observed. In an interview A.M., the Dieticity is a safe based on the touch. The example is a safe based of the touch of the touch. The example is a safe based of the touch of the touch. The example is a safe based of the touch of the touch of the touch. The example is a safe based of the touch of the to | maintain all essential trical, and patient care e operating condition. ervation, interview and the facility failed to freezers within properinge, in 1 of 1 facility deficit practice had the pact 161 of 161 ving food from the de: esservation tour was 7/9/13 at 10:04 A.M., an/Food Service for exercise for exercise food service for exercise fo | F000456 | 1. No residents were found have been affected by this deficient practice due to no reports or complaints of illness identified during this time. Dut the observation of this deficien practice, there were no potent hazardous foods observed. Nevertheless, all of the frozen foods in this freezer were immediately removed and sto in the kitchen's walk-in freeze immediately removed and sto in the kitchen's walk-in freeze and these items were immediately removed and stored in another freezer, no other residents had the potential of being affected this same deficient practice. Furthermore, this freezer was discarded and a replacement freezer is on order. | s rring nt tially pred rr. ere d by |
| | • | to be 0 (zero) degrees | | installation of the new freezer | , |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E4J11

Facility ID: 000001

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| | OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S COMPL | |
|-----------|---|--|---------|------------|---|---------------------------|------------|
| AND PLAN | OF CORRECTION | 155001 | A. BUII | LDING | 00 | 07/16/ | |
| | | 100001 | B. WIN | | | 07/10/ | 2010 |
| NAME OF F | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| HOOVER | RWOOD | | | | OOVER RD APOLIS, IN 46260 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | ļ | TAG | DEFICIENCY) | | DATE |
| | temperature lost the Dietician or temperature for were documen 20-24 degrees freezer temper month of June temperatures redegrees Fahre | anging from 20 to 24 | | | temperature logs will continue be closely monitored in accordance with departmental policy. Any temperature reading that are deficient will be immediately reported to the Maintenance Department for immediate follow-up. If the Maintenance staff is not able to address / repair this issue, the food from the freezer will be stored in another freezer until time that the temperature problem is resolved. | ngs O | |
| | provided by the at 1:00 P.M. T Each refrigerate a thermometer Fahrenheit and refrigeration is AM and PM and proper form. If recorded is not the discrepance immediately. It appropriate sin | e Dietician on 7/10/13 he policy indicated " or and freezer contains accurate to 3 degrees l is easily read. The checked daily in the d recorded on the the temperature within range, report y to the supervisor f the temperature is not ce the last reading was pecially perishables | | | 4. On a daily basis, the Food Service Director, Food Service Manager and Chefs will be monitoring the temperature log On an unannounced, bi-weekly basis for three months, and monthly thereafter, the Execut Director, Chief Financial Office and / or the Infection Prevention Nurse will be checking these temperature logs during kitche sanitation rounds. Any deficie practices will be addressed immediately with necessary repair, disciplinary action, polic development, and / or mandate inservice education. On a monthly basis, the Food Servic Director will be presenting a written report to the Quality Improvement committee regarding freezer temperatures repairs, etc. | gs. y ive er, on nt cy ed | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2013 FORM APPROVED OMB NO. 0938-0391

| | | IDENTIFICATION NUMBER: 155001 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | COMPL 07/16/ | ETED |
|--------------------------|----------------------|---|--|---|-----------------|----------------------------|
| NAME OF P | PROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP CODE OOVER RD | | |
| HOOVER | RWOOD | | | IAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | E RIATE | (X5) COMPLETION DATE |
| | | | | 5. Date of Completion: 8/14/13 | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
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| | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E4J11

Facility ID: 000001

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|--|--|----------------------------|--------|--|--------------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | 00 | COMPLETED | |
| | | 155001 | B. WIN | | | 07/16/2013 | |
| | | | B. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | OOVER RD | | |
| HOOVER | RWOOD | | | | APOLIS, IN 46260 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE | re | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | '- | DATE |
| | 483.70(h) SAFE/FUNCTION TABLE ENVIRON The facility must panitary, and comresidents, staff ar Based on obsethe facility faile room entry door for 11 resident and on 1 of 2 fl A 201, 208, and B 219, 216, 21 and 222) Findings included On 7/9/13 at 12 resident room entry door observed to be multiple scrape laminate coverion. On 7/10/13, fro AM, a further of conducted. Reconsisted of a part of the could be wider access to the conductes of lamin chucks of lamin. | AL/SANITARY/COMFOR Not provide a safe, functional, infortable environment for ad the public. Invation and interview, do to maintain resident in a good condition, rooms on 2 of 5 units, coors. (Room numbers do 213; Room | F000 | | F465 1. Residents residing in root 2A: 201, 213, 208 and rooms 219, 216, 217, 212, 210, 208, 204, and 222 were not found to have been affected by this deficient practice. No reports complaints from residents and or family members were identified. No injuries or ill effective been identified as a result his deficient practice. All damaged doors, were immediately repaired by the Maintenance Director and staff. (see attachment #7, pg 1-2) 2. Every resident room door the building will be inspected a repaired by the Maintenance Department by 8/14/13. As a result of this quality improvement measure, no other residents we have the potential of being affected by this same deficient practice. | ms 2B: o or / ects It of | |

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Event ID: 2E4J11

Facility ID: 000001

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
|--|---|--------------------------------|--------------------------|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 COMPLETED | | |
| | | 155001 | A. BUILDING B. WING | | 07/16/2013 |
| | | | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF F | PROVIDER OR SUPPLIE | R | | OOVER RD | |
| HOOVEF | N/OOD | | | IAPOLIS, IN 46260 | |
| HOOVER | (VVOOD | | INDIAN | AFOLIS, IN 40200 | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | l ` | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| ı | stripping on th | e narrower door where | | Maintenance logs will | |
| | the two doors | met when closed. The | | continue to be maintained on | |
| | damage was d | observed at various | | five nursing units. Staff will be | |
| | 1 | lower half of the doors | | encouraged to document any further door damages in the | |
| | l • | side corners for the | | maintenance logs. These log | s |
| | following room | | | are checked 6 days per week | |
| | | 13. | | all repairs are done as quickly | l l |
| | A Co | on O A conity Decree | | possible. On a monthly basis | |
| | | or, 2 A unit: Rooms | | Maintenance Director, Director | |
| | | On 7/15/13 at 9:30 | | and Assistant Director of | |
| | A.M., an addit | ional room, Room 208, | | Environmental Services, and | / or |
| | was observed to have a large chunk of laminate out at the bottom corner | | | the Executive Director will | |
| | | | | conduct maintenance rounds | in |
| | of the the sma | ıll door, with torn foam | | order to identify and further deficient practices. Any defic | iont |
| | stripping. | , | | practices will be documented | |
| | ou.ppg. | | | followed up with repair, | and |
| | R Second flo | or, 2 B unit: Rooms | | replacement, disciplinary action | on, |
| | | • | | policy development, and / or | , |
| | | , 212, 210, 208, 204, | | mandated inservice education | ۱. |
| | and 222. | | | | |
| | | | | | |
| | | v on 7/15/13 at 10:05 | | 4 Deficient procince ident | ritio d |
| | A.M., the Dire | ctor of Environmental | | 4. Deficient practices, ident from monthly environmental | inea |
| | Services indic | ated there were no | | rounds, will be reported in wri | tina |
| | current remod | eling or major repair | | to the Quality Improvement | ung |
| | programs star | ted, on-going, or | | committee on a monthly basis | s for |
| | l · • | s time. He indicated a | | review. Trends in deficient | |
| | · | t room remodeling | | practices may lead toward fur | ther |
| | 1 | ps at least 5 years in | | repair, replacement, training, | and |
| | ' ' ' ' | , | | / or disciplinary action. | |
| | | s planned. The flooring | | | |
| | | nt room was especially | | | |
| | targeted for up | ograde. | | 5. Date of Completion: | |
| | | | | 8/14/13 | |
| | In an interview | v on 7/15/13 at 10:25 | | | |
| | A.M., the Direct | ctor of Environmental | | | |
| | Services indic | ated a Maintenance | | | |
| | Communication | on Log book was | | | |
| | 1 | - J | 1 | 1 | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | OO | (X3) DATE : COMPL | | |
|---|---------------------|---|------------|--------|---|--------|------------|
| ANDILAN | OI CORRECTION | 155001 | | LDING | 00 | 07/16/ | |
| | | 100001 | B. WIN | | | 077107 | 2010 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| HOOVER | RWOOD | | | | OOVER RD APOLIS, IN 46260 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · · | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENCY) | | DATE |
| | | h unit for staff to record | | | | | |
| | any issues that | | | | | | |
| | | Laundry/Maintenance | | | | | |
| | • | eeded to address. | | | | | |
| | | mergency issues were | | | | | |
| | called to the M | | | | | | |
| | • | le indicated that It the doors was a | | | | | |
| | • | Director question;" and | | | | | |
| | | nave to talk with the | | | | | |
| | | Pirector to determine if | | | | | |
| | | ad been made for | | | | | |
| | • | ent room doors. He | | | | | |
| | • | acility had the ability | | | | | |
| | | to re-laminate doors | | | | | |
| | | damaged. He believed | | | | | |
| | | ce Director had a | | | | | |
| | | aintenance program, | | | | | |
| | - | re if checking resident | | | | | |
| | | a regular basis was on | | | | | |
| | the list. | | | | | | |
| | | | | | | | |
| | In an interview | on 7/15/13 at 10:45 | | | | | |
| | A.M., the Main | tenance Supervisor | | | | | |
| | | ecked the resident | | | | | |
| | room doors abo | out every 1-2 months. | | | | | |
| | He indicated he | e was able to | | | | | |
| | re-laminate, fill | gouges, sand the | | | | | |
| | areas down, re | -paint, or repair the | | | | | |
| | damage as neo | cessary. He indicated | | | | | |
| | the staff did no | t generally notify | | | | | |
| | Maintenance a | bout damaged doors, | | | | | |
| | he just had to | check them. He | | | | | |
| | indicated he ha | nd tried using a plastic | | | | | |
| | guard on the lo | wer portion of the | | | | | |
| | <u> </u> | | | | | | |

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Event ID: 2E4J11

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PRINTED: 08/05/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155001 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/16/2013 |
|---|---|---|
| NAME OF PROVIDER OR SUPPLIER HOOVERWOOD | STREET ADDRESS, CITY, STATE, Z 7001 HOOVER RD INDIANAPOLIS, IN 46260 | IP CODE |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TOTAL DEFICIENCY | ON SHOULD BE COMPLETION |
| doors at one time, but the panel didn't work all that well in protecting the doors from damage. | | |
| 3.1-19(f) | | |
| | | |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E4J11

Facility ID: 000001

If continuation sheet

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| AND PLAN OF CORRECTION IDE | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | |
|--|--|-----------------------|--|-----------------------------------|--|
| | | A. BUILDING COMPLETED | | | |
| 1 | 55001 | B. WING | | 07/16/2013 | |
| NAME OF PROVIDER OR SUPPLIER HOOVERWOOD | | 7001 HO INDIAN | ADDRESS, CITY, STATE, ZIP CODE OOVER RD APOLIS, IN 46260 | | |
| · · · | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| ` ` | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | | |
| | C IDENTIFYING INFORMATION) | TAG | DEFICIENCE | DATE | |
| SSIBLE The facility must male each resident in accorprofessional standar are complete; accurate readily accessible; a organized. The clinical record mainformation to identify of the resident's assocare and services program and program and program and program and program and program assed on intervier review, the facility document the sking clarify conflicting and stage 3 pressure either present on, admission, for 1 coreviewed for present (Resident #24) Findings include: The closed clinical Resident #24 was 7/12/13 at 2:43 P was admitted on a diagnoses which not limited to, Sta | must contain sufficient fy the resident; a record lessments; the plan of rovided; the results of creening conducted by less notes. We and record by failed to accurately in condition and information about a le ulcer which was less or developed after, of 4 residents lessure ulcers. al record for less reviewed on less. M. The resident lincluded, but were lage 4 colorectal listases to the liver, lostomy surgery, | F000514 | 1. Resident #24 expired on 4/10/13 due to the progressior end-stage rectal cancer. Her pressure ulcer was present up admission. The resident was placed on a low air loss mattre upon admission and received skin care interventions per physician orders beginning 3/28/13. The resident never exhibited any pain or discomfor originating from this pressure ulcer. Per clinical review, this pressure ulcer did not worsen from the time it was identified the time of her death. As a resit is believed that this resident was not found to have been affected by this deficient practice. | on ess ort until ult, | |

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Event ID: 2E4J11

Facility ID: 000001

If continuation sheet Page 32 of 36

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|--|---------------------|---|--------------------------|--|-----------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 COMPLETED | | |
| | | 155001 | A. BUILDING B. WING | | 07/16/2013 |
| | | | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | IOOVER RD | |
| HOOVER | RWOOD | | | NAPOLIS, IN 46260 | |
| | | | | T | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) |
| PREFIX TAG | ` ` | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | COMPLETION DATE |
| TAG | | * | TAG | BEITEE.KC1, | DATE |
| | failure, uretera | | | | |
| | | and diabetes. The | | 2. As a quality improvemen | t |
| | resident expire | ed on 4/10/13. | | measure, the medical records | |
| | | | | skin care documentation of | |
| | A facility "Pre- | | | pressure areas of all current a | |
| | | form, dated 3/19/13, | | future residents with pressure | |
| | indicated the r | esident had bilateral | | ulcers will be reviewed by the | |
| | sacral spine p | ressure ulcers, "unable | | Nursing Administration and Wound Nurse. (Record revie | ws |
| | to visualize, dı | ressing: mepliex foam." | | of current residents will be | |
| | | | | completed by 8/14/13. Recor | d |
| | An "Admission | Nursing Evaluation" | | review of future residents will | be |
| | | 20/13 at 2:00 P.M., | | ongoing). The clinical review | |
| | · · | resident had a scar on | | these records will assure that | |
| | | and a colostomy. No | | pre-admission documentation | |
| | | s were identified or | | being used to alert nursing sta potential skin issues and that | |
| | documented of | | | nursing admission assessmen | |
| | documented d | in the form. | | accurately captures the reside | |
| | A "Clinical Sur | mmary," dated 3/25/13 | | current skin issues upon admission. The MDS Nurse a | and |
| | | by a facility Assistant | | the Nurse authoring the 450- | |
| | - | rsing, indicated " | | assure that their documentation | |
| | | cility with an open area | | consistent with the admission | |
| | | spine, with significant | | assessment. Any deficient | |
| | | skin breakdown. | | practices identified as a result | of |
| | | | | these record audits will be | ugh |
| | | [Low Air Loss] | | followed up immediately throu disciplinary action, policy | igii |
| | | ay of admission, | | development, and / or manda | ted |
| | ordered nouse | e supplement" | | inservice education. | |
| | A "\Mound/Ski | n Healing Record" form, | | | |
| | | , indicated the onset | | | |
| | | • | | 3. Upon admission, the | |
| | | e 3 coccyx pressure | | admitting nurse and Nursing | |
| | | 7/13, and measured 1 X | | Supervisor will be responsible | for |
| | 2 X .2 cm. (ce | ntimeters). | | assuring that skin pressure ar | eas |
| | | | | are accurately identified and | |
| | , | nimum Data Set) | | treatments are ordered and | |
| | assessment w | as completed on | | followed per physician order. | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MU | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|---------------------|------------------------------|----------------------------|--------|---|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DINC | 00 | COMPLI | ETED |
| | | 155001 | A. BUIL B. WIN | | | 07/16/2 | 2013 |
| | | 1 | D. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIE | R | | 1 | OOVER RD | | |
| HOOVEF | RWOOD | | | | IAPOLIS, IN 46260 | | |
| | | | | | 1 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | | - | DATE |
| | 4/2/13. Sectio | • | | | This practice and standard will also assure that any pressure | | |
| | · · | licated the resident had | | | areas identified throughout a | | |
| | one or more ui | nhealed pressure | | | resident's admission will also | be | |
| | ulcers at Stage | e 1 or higher, that the | | | accurately addressed with | | |
| | current unheal | ed pressure ulcer was | | | assessment and treatment. T | he | |
| | a Stage 3, and | that the pressure ulcer | | | Unit Manager, Nursing | | |
| | | n admission. The | | | Administration, Nursing | | |
| | · • | CAA (Care Area | | | Supervisors, and / or MDS | | |
| | | Summary, indicated | | | Assessment Nurses will be responsible for reviewing wou | nd | |
| | | admitted with a Stage | | | documentation and admission | | |
| | III area to her | | | | assessments within 48 hours | | |
| | | Sacrum on | | | admission to assure that all | | |
| | admission" | | | | pressure areas are addressed | lin | |
| | | | | | the care plan. | | |
| | | 3:30 P.M., the Director | | | | | |
| | _ | given the opportunity | | | | | |
| | to submit any | documentation that | | | An incoming for liganood number | in a | |
| | clarified when | the resident's pressure | | | An inservice for licensed nursi personnel will be conducted b | - | |
| | ulcer develope | ed. | | | 8/14/13 to review this deficien | · I | |
| | | | | | practice and to discuss the pla | | |
| | On 7/16/13 at | 11:20 A.M., the | | | of correction, documentation | | |
| | | sing provided a paper | | | audits, ongoing monitoring, et | c. | |
| | | in earlier interview | | | | | |
| | | mentation. She | | | | | |
| | indicated the " | | | | 4 Any deficient proctice | | |
| | | | | | 4. Any deficient practice identified as a result of skin | | |
| | | orm was completed by | | | documentation audits by the L | Jnit | |
| | 1 | on staff using acute | | | Manager, Nursing Administrat | | |
| | | nformation. A copy of | | | Nursing Supervisors, and MDS | | |
| | | n, dated 3/18/13, | | | Assessment Nurses will be | | |
| | indicated "Pres | ssure Ulcer: bilateral | | | addressed immediately through | jh | |
| | sacral spine; u | nable to visualize; | | | disciplinary action, policy | | |
| | dressing: Mep | liex foam." | | | development, and / or mandat | | |
| | | | | | inservice education. Any trend of deficient practice will be | us | |
| | The "Clinical S | summary" information | | | reported by Nursing | | |
| | was completed | - | | | Administration in a written rep | ort | |
| | • | nformation. The | | | to the Quality Improvement | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2013 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CC | ONSTRUCTION | (X3) DATE S COMPL | | |
|---|---------------------|------------------------------|------------|-------------|---|--------|------------|
| AND PLAN | OF CORRECTION | 155001 | A. BUI | LDING | 00 | 07/16/ | |
| | | 100001 | B. WIN | | | 07/10/ | 2010 |
| NAME OF P | ROVIDER OR SUPPLIER | ₹ | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| HOOVER | RWOOD | | | | OOVER RD APOLIS, IN 46260 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | • | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | _ | ember who completed | | | Committee on a monthly basis Such monitoring efforts will | | |
| | the summary h | • | | | continue ongoing as a continu | ous | |
| | evaluated the r | resident's skin. | | | quality improvement measure. | | |
| | The MDS nurs | e competing the CAA | | | | | |
| | | k her information from | | | | | |
| | the preadmissi | on assessment | | | 5. Date of Completion: | | |
| | paperwork and | I from the nurse | | | 8/14/13 | | |
| | reporting the p | ressure sore on | | | | | |
| | 3/27/13. The N | MDS nurse had not | | | | | |
| | previously visu | ally assessed the | | | | | |
| | resident's skin. | | | | | | |
| | In the interview | v, the Director of | | | | | |
| | | ted the hospital | | | | | |
| | _ | d Transfer" form did not | | | | | |
| | _ | sure ulcer, and that the | | | | | |
| | • • | n did not address a | | | | | |
| | pressure ulcer | in her admission note | | | | | |
| | dated 3/21/13. | | | | | | |
| | The Director of | f Nursing indicated she | | | | | |
| | | the facility admitting | | | | | |
| | | orted she was positive | | | | | |
| | | e addressed an open | | | | | |
| | | dmission form) if one | | | | | |
| | was present, ju | • | | | | | |
| | addressed the | abdominal scar and | | | | | |
| | colostomy. Th | e Director of Nursing | | | | | |
| | indicated she h | nad reviewed all of the | | | | | |
| | shift reports fro | om 3/20/13 through | | | | | |
| | 3/28/13, and th | ne first reporting of the | | | | | |
| | area was on 3/ | 27/13. | | | | | |
| | 3.1-50(a)(2) | | | | | | |
| | | | | | | | |

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Event ID: 2E4J11

Facility ID: 000001

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PRINTED: 08/05/2013 FORM APPROVED OMB NO. 0938-0391

| | | IDENTIFICATION NUMBER: 155001 | A. BUILDING B. WING | 00 | COMPLETED 07/16/2013 | | | |
|--------------------------|---------------------|---|--|---|----------------------|--|--|--|
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 7001 HOOVER RD | | | | | |
| HOOVER | :WOOD | | | APOLIS, IN 46260 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETION DATE | | | |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2E4J11

Facility ID: 000001

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